Testimony of
The Connecticut ENT Society
The Connecticut Society of Eye Physicians (CSEP), and
The Connecticut Dermatology and Dermatologic Surgery Society (CDS)
In Support of
SB 1004; An Act Concerning Cooperative Health Care Arrangements
And Standards in Contracts between Health Insurers and Health Care Providers
Given by Scott Schoem
Before the Judiciary Committee

March 20, 2009

Good afternoon Senator McDonald, Representative Lawlor and other distinguished members of this committee. My name is Scott Schoem and I am a board certified otolaryngologist practicing pediatric ENT medicine in Hartford, CT. I am here to represent over 700 doctors in the ENT, Eye and Dermatology medical professions in support of **SB 1004 Cooperative Health Care Arrangements and Standards In Contracts between Health Insurers and Health Care Providers** and to offer an amendment that will further strengthen this much needed piece of legislation.

Today we have heard supportive testimony from Dr. William Ehlers on the importance of this bill and how it will help to level the playing field for health care providers. In addition, he provided testimony on the length of time, healthcare providers have been committed to this proposed legislation. I will not reiterate what my esteemed colleague has already recited, but would like to touch upon a standard issue that is not included in SB1004 and offer some insight as to why health care providers feel that the "bundling of services" -which are not in compliance to CPT code guidelines- should be addressed and included in this important bill.

First of all I would like to give some insight as to what health care providers are dealing with in regard to "bundling" and why this egregious practice erodes the healthcare delivery system. When a health provider enters into a contract with a managed care organization-it is usual and customary to define billing guidelines. In all the contracts I have seen and participate with the managed care organization requires that for billing purposes I must bill according to Current Procedural Terminology(CPT) Guidelines(I have taken the liberty of providing a few pages in this guideline directory). These guidelines are universally accepted and associate each procedure, service, exam, test, etc with a 5 digit code for the purpose of communicating the exact service I have performed to the MCO for appropriate and agreed upon payment. This is a simple concept and easily adhered to since every procedure, test, exam etc has specific criteria and definitions which must be met to qualify for billing. If a provider fails to comply with these guidelines and bills for something he has not performed he is at risk for insurance fraud – which carries severe penalties- including loss of licensure for the provider.

The practice of bundling and downcoding is universally done by every carrier to every medical specialty. It is a way of reducing "medical loss ratios" a term designated to represent payments paid out on subscriber benefits.

Unfortunately, there are no laws protecting providers from practices such as bundling or the automatic down coding of a level of exam or service. A contract should have the same standards for both parties and if a provider is required to pay using these same standard guidelines.

Why does this erode the health care delivery system? We all talk about and realize the importance of access and improving the efficiency in the delivering of health care. But what we may not realize is that Managed Care's deliberate practice of bundling a claim for multiple services together for the reduction of pay -outs directly reduces access- by making a patient, who could have had both procedures done on the same day, come back and fill another time slot for patient care. It also reduces both the efficiency of the provider and the consumer. Many times patients have to take another day off from work; this cost is now passed on to their employer or is a loss of pay for the consumer. In this day and age- no one can afford to waste time, energy or resources. We have an opportunity to address this issue and work towards easing the health care provider shortage -which is looming and conserve health care dollars. By disallowing inappropriate behavior by the Managed Care Industry we will improve the health care delivery system and promote quality and efficiency.

In closing I would like to offer the following amendment in bold underline for consideration by this committee. It is an amendment that would put all players in the delivery of healthcare on the same playing field. Thank you.

Sec. 2. (NEW) (*Effective October 1, 2009*) (a) As used in this section:
118 (1) "Contracting health organization" means (A) a managed care
119 organization, as defined in section 38a-478 of the general
statutes, or
120 (B) a preferred provider network, as defined in section 38a-479aa
of the
121 general statutes; and (2) "physician" means a physician or
surgeon,
122 chiropractor, podiatrist, psychologist, optometrist, natureopath
or
123 advanced practice registered nurse.
124 (b) Each contract for services to be provided to residents of this
state
125 entered into, renewed, amended or modified on or after October 1,
126 2009, between a contracting health organization and a physician
shall
127 include provisions that: (1) Provide an explanation of the
physician
128 payment methodology, the time periods for physician payments, the
129 information to be relied on to calculate payments and adjustments
and
130 the process to be relied on to resolve disputes concerning
physician
131 payments; and (2) require that the contracting health organization
132 provide to each participating physician a complete copy of all
current
133 procedural terminology codes and all current reimbursements for
such
134 codes that determine the physician's reimbursement for the entire
135 contract period.
136 (c) No contract for services to be provided to residents of this
state
137 entered into, renewed, amended or modified on or after October 1,
138 2009, between a contracting health organization and a physician
shall

include any provision that allows the contracting health organization or physician to unilaterally change any term or provision of the agreed-upon contract, including, but not limited to, any term or provision concerning: (1) Fee schedules or provider panels; (2) the physician's ability to discuss or negotiate the terms of the contract; or (3) the physician's ability to terminate the contract unless the change is required by law. **(4) the bundling of services contrary to CPT Guidelines**